IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 75-1690

T. M. "JIM" PARHAM, ET AL., *Appellants*,

v.

J. L. AND J. R., ET AL., *Appellees*.

Appeal from the Judgment of the United States District Court for the Middle District of Georgia

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BRIEF OF *AMICI CURIAE*

American Orthopsychiatric Association, Children's Defense Fund of the Washington Research Project, Inc., Federation of Parents Organizations for the New York State Mental Institutions, Mental Health Association, National Association of Social Workers, National Center for Law and the Handicapped, and National Juvenile Law Center

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INTEREST OF AMICI CURIAE

Amici Curiae are seven organizations of mental health professionals, parents of children with emo-

tional handicaps and child advocates concerned with the legal rights and effective delivery of services to these children.[1]

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[1] (1) The American Orthopsychiatric Association, an interdisciplinary organization of 4,000 members including psychiatrists, psychologists, social workers, educators and allied professionals concerned with the problems, causes and treatment of abnormal behavior;

(2) The Children's Defense Fund of the Washington Research Project, Inc. (CDF), a national, nonprofit, public interest organization which gathers evidence about, and attempts to address systematically, the conditions and needs of children in this country. CDF seeks to correct the problems uncovered in its research through the monitoring of federal and state administrative policies and practices, litigation, the dissemination of public information and the provision of support to parents and local community groups representing children's interests. One of CDF's primary concerns is children who have been unnecessarily institutionalized or placed in inadequate facilities. CDF attorneys are serving as counsel for plaintiffs in *Poe* v. *Califano*, No. 74-1800 (D.D.C.) (three-judge court), a case currently pending on cross-motions for summary judgment, which involves the same procedural due process question presented in this case.

(3) The Federation of Parents Organizations for the New York State Mental Institutions, an organization of 30,000 parents, relatives and citizens concerned with the treatment of patients in New York Department of Mental Hygiene facilities;

(4) The Mental Health Association, a citizens organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally ill;

(5) The National Association of Social Workers, an organization of 70,000 professional social work members with chapters in 50 states devoted to the advancement of sound public policy for social work consumers as well as professionals;

(6) The National Center for Law and the Handicapped, established with HEW funding to provide legal assistance to promote the full social and legal integration of all disabled Americans;

(7) The National Juvenile Law Center, a national legal services support center, funded by contract with the Legal Services Corporation through a grant to St. Louis University School of Law. The Center provides assistance to legal services programs, public defenders and private attorneys representing indigent clients in the area of juvenile and family law. From time to time, the attorneys employed by the Center also act as *amicus curiae* in cases involving issues of substantial public interest and importance, including participation as *amicus curiae* in *J.L. and J.R.* v. *Parham* in the district court.

Amici have a strong personal and professional commitment to the delivery of high quality mental health services to children and adolescents. They believe that wherever possible such services should be administered in the community and on a voluntary basis. Children and adolescents are best treated and cared for by their own families in their normal surroundings rather than by removal from their homes and segregation in institutions for the mentally ill. Moreover, *amici* believe that in the great majority of cases non-institutional treatment or training can be successful when families are given the community support and specialized help they need for their mentally ill children. Accordingly, the *amicus* groups have worked for the creation of better and more diversified community-based facilities and programs for the mentally ill. They have increasingly emphasized the need for such programs and facilities for these children because they believe that appropriate and non-stigmatizing help in the early years provides the greatest opportunity for producing healthy and well-functioning citizens.

Amici do not oppose institutionalization of children and adolescents in all cases. They recognize that some children have such severe illnesses or need such specialized services that residential care outside the family may be necessary. But they are concerned that children should not be removed from normal family, peer and community contacts without a formalized and

searching inquiry into their needs. Although the majority of parents are normally conscientious advocates for their children, they are often beset by conflicts and confusion of their own and by apathy on the part of official agencies. Parents are often unaware of alternatives to institutionalization, when in fact their children might be treated in the community. Although *amici* are sensitive to the sometimes competing demands of due process and treatment, they believe that an erroneous decision to treat a child through confinement in a closed mental hospital may seriously jeopardize the health, safety and development of the child. Moreover, *amici* submit that a reasonable accommodation of treatment and due process demands can be achieved and further, that the requirement of evidentiary hearings in connection with proposed institutionalization of children and adolescents will confer important therapeutic and social benefits on the child and the family.

Amici represent mental health professionals—psychiatrists, psychologists and social workers—and parents, who deal on a day-to-day basis with the problems of emotionally disturbed children and adolescents. This brief will inform the Court of studies and experience relevant to the question of how and when due process procedures should be applied to the commitment of children in institutions for the mentally ill.

As the Court has been informed in a letter to the Clerk dated August 25, 1977, from counsel for appellants and appellees, *amici* have received consent from both parties to file this brief.

STATEMENT OF THE CASE

This class action was brought pursuant to 42 U.S.C. § 1983, 28 U.S.C. 1343(3) in the United States District

Court for the Middle District of Georgia challenging Georgia statute, 1833 Georgia Code Ann. § 88-503.1, which authorizes the indefinite confinement of children to state mental institutions with consent of their parents or guardians and without an evidentiary hearing. Under this section, applications for "voluntary" observation and diagnosis at a state mental health facility may be made on behalf of any child under 18 years of age by his parent or guardian. In the case of a dependent or neglected child, the guardian is frequently the State welfare department. If, following a staff interview, the superintendent of the institution finds the child "to show evidence of mental illness and to be suitable for treatment," the child may be detained at the facility "for such period and under such conditions as may be authorized by law."

The minor plaintiffs alleged that they were denied due process of the law under the Fourteenth Amendment to the U.S. Constitution because they were involuntarily confined in state mental hospitals without being afforded a meaningful and complete opportunity to be heard.[2]

After considering more than 20 depositions from lay and expert witnesses and relevant hospital records and statistical evidence, a three-judge district

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[2] Plaintiffs contended further that commitment to state mental facilities without initial and periodic consideration of placement "in the least drastic environment" violated their rights to substantive due process under the Fourteenth Amendment to the U.S. Consitution. The court ordered that the approximately 46 members of plaintiff class who were identified as amenable to treatment in a less drastic environment be provided with such facilities "as soon as reasonably appropriate." For the reasons set forth more fully at n. 3 *infra*, *amici* believe that this Court should not reach this issue in the context of this case.

court composed of Circuit Judge Bell and District Judges Owens and Bootle ruled, unanimously, that the "voluntary" admission and commitment procedures of § 88-503.1 were unconstitutional. (J.S. 1a) (412 F. Supp. 112).

Following the decision of the court below, the defendants appealed the judgment to this Court and made application for a stay pending appeal. A stay was denied by the district court, 412 F. Supp. 141 (1976), but granted by this Court, 96 S. Ct. 1503 (1976). Probable jurisdiction was noted on May 31, 1977, 45 U.S. L.W. 3733.

SUMMARY OF ARGUMENT

This case requires the Court to decide first, whether a state may itself, acting as guardian, directly confine children in state mental institutions without evidentiary hearings and, second, whether the state may by statute authorize parents or non-public guardians to confine children in such facilities without the protection of a hearing.

This Court has often been called upon to mediate between the interests of the family in conducting its affairs free from arbitrary state interference and the interests of the state in protecting the welfare of its young citizens.

In doing so, it has recognized a presumption in favor of parental prerogatives, stating that "the custody, care and nurture of the child reside first in the parents." *Prince* v. *Massachusetts,* 321 U.S. 158, 166 (1944). But it has also stressed that the state may intervene with regard to parental decisions where those "decisions will jeopardize the health or safety of the

child, or have a potential for significant social burdens." *Wisconsin* v. *Yoder,* 406 U.S. 205, 234 (1972). In addition, this Court has granted to children of all ages significant procedural due process rights when the state attempts to remove them from their homes and place them in juvenile institutions as a result of alleged delinquent conduct. *In re Gault,* 387 U.S. 1 (1967). This case, however, involves neither a state's efforts to curtail family authority nor its efforts directly to remove children from their homes; rather it involves an attempt by the state either directly to initiate institutionalization of children who are its wards without a hearing of any kind or, indirectly, to participate with or authorize parents or other guardians to institutionalize their children in state mental facilities, also without a hearing of any kind.

This Court has previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson,* 422 U.S. 563, 580 (1975) (Burger, C.J., concurring); *In re Ballay,* 482 F. 2d 648 (D.C. Cir. 1973). And there can be little doubt that due process safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. Similiarly, the right to procedural due process also applies where the commitment is not labeled "involuntary" but the state is nonetheless an active participant in the institutionalization of children, either through its initiation of admission as their guardian or, where the commitment is initiated by parents, through its acceptance of the children and its operation of the facility in which they are placed.

Therefore the critical question before this Court is not whether due process applies to the commitment of children to mental institutions but, rather, what process is due. *Mathews* v. *Eldridge,* 424 U.S. 319 (1976).

An analysis of the potential harm to children from an erroneous commitment decision, of the risk of an erroneous decision under the Georgia "voluntary" commitment statute, and of the countervailing interests asserted in support of the Georgia statute shows that the present Georgia procedure is constitutionally inadequate. An unnecessary commitment to a mental institution imposes very substantial harm on a child both because the process of institutionalization is inherently detrimental and because harmful conditions exist in many mental institutions in this country. As a result of institutionalization, children's natural family and community ties are often severed. Moreover, the impact of institutionalization upon the intellectual and emotional development of children can result in irreversible damage to their future potential as adults. And, even if they are eventually released, the mere fact that children have once been institutionalized carries with it a lifelong stigma which may later cause them to be denied employment, licensing, education and access to health benefits.

The risk of error in mental health professionals' decisions to admit children is very high. Such decisions are frequently made hurriedly and with very little information. Institutional personnel have a strong predisposition to recommend commitment in doubtful cases, and psychiatric diagnoses are recognized to be highly unreliable. Because the high risk of erroneous commitment decisions is coupled with the grave harm

of commitment, an evidentiary hearing is constitutionally required.

The countervailing interests in the present Georgia statute which might be asserted by the State do not outweigh the child's need for an evidentiary hearing. Such a hearing is not inconsistent with the legitimate interests of parents or with the preservation of family autonomy. Parental decisions to commit their children are often the product of great stress, of acquiescence in recommendations by institutional personnel or lack of knowledge about available treatment alternatives. Frequently, parents' own interests or the interests of other family members are in conflict with what is best for the child. Accordingly, it cannot be assumed that parents will automatically make this decision based solely on what they perceive to be the child's best interests or that they are sufficiently impartial to judge those interests. Further, by providing an opportunity to explore alternatives to institutionalization, an evidentiary hearing would help to preserve the family's integrity.

When the state acts *in loco parentis* to initiate the institutionalization of a mentally handicapped child, concerns of family autonomy are not relevant and prolonged institutionalization is more likely. Nor does the state have a fiscal or administrative interest which outweighs the child's need for the evidentiary hearing.

Thus, analysis of the criteria set forth in *Mathews* leads to the conclusion that children who are to be committed to mental institutions have a due process right to an evidentiary hearing. Without expressing an opinion on such related issues as the proper forum for such a hearing or the applicability of formal rules of evi-

dence, *amici* submit that any hearing procedure adopted must contain, at least, the minimum safeguards that have traditionally been required in cases involving deprivation of liberty: notice, counsel and the opportunity for the child subject to commitment to confront and cross-examine witnesses.

In sum, providing an evidentiary hearing to children subject to confinement in mental institutions can help to decrease unnecessary and damaging institutionalization and to bring to bear on the unfortunate situation of emotionally disturbed children the attention and community resources they require.

ARGUMENT

I. THE DUE PROCESS CLAUSE APPLIES TO THE COMMITMENT OF A CHILD TO A STATE MENTAL INSTITUTION REGARDLESS OF THE CONSENT OF THE PARENT OR GUARDIAN.

This case raises the question of a child's constitutional right to due process of the law when his liberty is at stake because of a decision by his parent or guardian (including the state acting as guardian) to commit him to a state mental institution.[3] This Court has

[3] This brief will restrict itself to the procedural due process issue pending before this Court, *i.e.*, those procedures required by the Constitution in connection with a child's commitment to a mental institution. *Amici* recognize that a substantive due process issue has also been raised in the Questions Presented: whether a child who has been properly found to be in need of treatment for a mental illness must be placed for treatment in the least restrictive alternative. *Amici* support the position of appellees on this issue. But we believe that a decision on the issue in the context of the instant case, where it has been intertwined with the procedural due process issue, would be premature. Should the judgment of the court below on the procedural question be affirmed, the substantive due process issue would lack the requisite ripeness for a decision by this Court. Since an affirmance on the procedural issue would mean that the children committed under the invalid procedure were unconstitutionally committed, the appellant Department's first order of business would be to hold constitutionally appropriate hearings to determine if the children are in fact in need of treatment according to Georgia law. The substantive due process issue as to the nature of the treatment to which a child is constitutionally entitled does not arise until it is first properly determined that he is in need of treatment. *Cf. Richardson* v. *Wright*, 405 U.S. 208 (1972). If, on the other hand, the Court were to uphold the Georgia commitment procedure, thereby ratifying the State's decision to commit the children, we would suggest that the Court reserve judgment on the substantive due process issue and remand the case for the development of a more complete record on the issue because the record developed below focuses almost entirely on the procedural question. Because the substantive due process claim does not challenge the constitutionality of a Georgia statute or regulation on its face, it appears that in the event of a remand, this issue could be heard by a single district judge. *See Morales* v. *Turman*, 430 U.S. 322 (1977).

previously recognized that involuntary commitment to a mental facility involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Certainly for adults, such a deprivation must be attended by due process procedural safeguards. *See O'Connor* v. *Donaldson*, 422 U.S. 563, 580 (1975) (Burger, C.J., concurring).[4] "Commitment must be justified on the basis of a legitimate state interest, and reasons for committing a particular individual must be established in an appropriate proceeding." *Id.* at 580. And there can be little doubt that due process

[4] *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973). *See also Lynch* v. *Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974); *Lessard* v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *remanded on other grounds*, 414 U.S. 473, *redecided*, 379 F. Supp. 1376 (1974), *remanded on other grounds*, 421 U.S. 957 (1975), *redecided*, 413 F. Supp. 1318 (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *Bell* v. *Wayne County*, 384 F. Supp. 1085 (E.D. Mich. 1974); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975).

safeguards would also apply to any attempt by the state to initiate the involuntary institutionalization of a child. This Court ruled in *In re Gault,* 387 U.S. 1 (1967), that despite the state's *parens patriae* purpose in juvenile delinquency proceedings, due process required a judicial hearing before children could be removed from their homes and placed in juvenile institutions.[5]

Similarly, the right to procedural due process also applies where the commitment is not labeled "involuntary" but where the state is nonetheless an active participant in the institutionalization of children (a "massive curtailment of liberty"), either through its initiation of admission as their guardian or, when the commitment is initiated by parents, through its acceptance of the children and its operation of the facility in which they are placed.[6] Children in mental institutions very often suffer not only loss of liberty but also serious psychic and emotional harm, risks to intellectual and emotional development and stigma greater than that faced by children confined in juvenile detention facili-

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[5] *See also In re Winship,* 397 U.S. 358 (1970); *Breed* v. *Jones,* 421 U.S. 519 (1975); *cf. Goss* v. *Lopez,* 419 U.S. 565 (1975). This Court's decision in *Ingraham* v. *Wright,* 430 U.S. 651 (1977), is fully consistent with the principle that due process applies to the deprivation of a child's liberty. While corporal punishment in the public schools was found not to require a prior hearing, the Court nonetheless held that the imposition of corporal punishment implicated a constitutionally protected liberty interest under the Fourteenth Amendment. *Id.* at 672.

[6] This case does not involve parental commitment of children to private mental facilities pursuant to a state statute. Hence, this brief will not address the issue of whether such commitments are within the protection of the Fourteenth Amendment.

ties.[7] "In view of this it would be extraordinary if the Constitution did not require the procedural regularity and the exercise of care implied in the phrase 'due process.' " *In re Gault,* 387 U.S. 1, 27, 28 (1967).[8]

Therefore the critical question before this Court is not whether due process applies, but rather what procedures constitute "due process of law." *Morrissey* v. *Brewer,* 408 U.S. 471 (1972).[9]

II. UNDER THE TEST SET FORTH IN *MATHEWS* v. *ELDRIDGE,* THE PROCEDURES PROVIDED BY GEORGIA CODE SECTION 88-503.1 ARE CONSTITUTIONALLY INADEQUATE.

Under Georgia Code Section 88-503.1, the decision to admit a child who has been "volunteered" for com-

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[7] *Amici* do not suggest that the Fourteenth Amendment is applicable simply because an institutionalized child is likely to suffer "grevious loss", *Smith* v. *Organization of Foster Families for Equality and Reform,* 431 U.S. ——, 45 U.S.L.W. 4638, 4644 (1977). Rather, as the district court pointed out, the Fourteenth Amendment applies because the confinement of a child in a mental institution against his will interferes with his right to liberty in the most fundamental and profound sense. J.S. 48a, 49a. *Cf. Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972); *In re Gault,* 387 U.S. 1, 27 (1967).

[8] The fact that commitment to a mental facility is based on the child's need for care and treatment and not on the commission of a specified wrongful act does not change the need for due process protection. An adult whose commitment is grounded on his status as a sexual psychopath or a mentally disabled person is clearly entitled to a hearing as to whether he meets the statutory criteria for the status. *See Specht* v. *Patterson,* 386 U.S. 605 (1967); *cf. Jackson* v. *Indiana,* 406 U.S. 715 (1972). In addition, a decision that a disturbed child needs institutionalization is usually based in part on specific behavior attributed to the child, which may be subject to factual dispute.

[9] *See also, Board of Regents* v. *Roth,* 408 U.S. 564, 566-572 (1972).

mitment by his parent or guardian is made by the superintendent of the mental facility on the basis of a staff interview. No evidentiary hearing is provided.

In *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), this Court identified the factors that must be considered in determining whether such a procedure meets the requirements of due process:[10] first, the potential harm to the individual flowing from an erroneous decision; second, the risk of an erroneous decision under the challenged procedure; and third, the countervailing interest asserted in support of the challenged procedure.

Consideration of these factors makes clear that the present Georgia procedure is constitutionally inadequate.

A. The Decision to Institutionalize a Child Interferes with the Child's Liberty and Development and Presents Substantial Likelihood of Serious Irreversible Harm.

Institutionalization, by its very nature, has a severe impact on a child's liberty. The child is taken from his family and is subjected to the rigid structure and rules of a closed facility, including locked wards, isolation cells, physical and chemical restraints and restriction of contact with the extrahospital community.[11]

[10] *See also, Smith* v. *Organization of Foster Families for Equality & Reform*, 431 U.S. ——, 45 U.S.L.W. 4638, 4646 (1977); *Cafeteria & Restaurant Workers Union* v. *McElroy*, 367 U.S. 886 (1961).

[11] *See, e.g., Price* v. *Sheppard*, 239 N.W.2d 905 (Minn. 1976) (use of electroconvulsive therapy on minors); Mitchell, *Experimentation on Minors: Whatever Happened to Prince* v. *Massachusetts?* 13 Duquesne L. Rev. 919 (1975) (medical experimentation performed on minors in mental institutions). Cf. *Hearings on the Use of Children as Subjects in Biomedical and Behavioral Research before the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research* (April 9, 1976) (Testimony of Dr. Robert Sprague).

Of course, the degree of liberty children enjoy differs from adults', since they are subject in varying degrees to the control of their parents. But there is little question that a child's liberty of movement and how he spends his time is substantially restricted when he moves from home and neighborhood into a mental facility. The change in his situation is often not qualitatively different from that of the delinquent child placed in a rehabilitative facility by the juvenile court, a move which this Court has already circumscribed with hearing procedures.[12]

In addition to restrictions of physical liberty, institutionalization for any substantial period of time can cause other equally serious harms to children. Its impact on their intellectual and emotional development can result in irreversible damage to their future potential as adults. Moreover, the mere fact of institutionalization carries with it a lifelong stigma which may prejudice them in admission to employment, licensing, higher education and access to health benefits.

1. Institutionalization Can Result in Loss of Family and Community Ties.

When a child is institutionalized for any period of time,

> "his world becomes 'a building with white-washed walls, regimented routine and institutional hours. . .' Instead of mother and father and sisters

[12] *See Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968). "It is the likelihood of involuntary incarceration—whether for punishment as an adult for a crime, rehabilitation as a juvenile for delinquency, or treatment and training as a feebleminded or mental incompetent—which commands observance of the constitutional safeguards of due process."

> and brothers and friends and classmates, his world is peopled by guards, custodians, [and] state employees. . . ."

In re Gault, 387 U.S. 1, 27 (1967), quoting Holmes' Appeal, 379 Pa. 599, 616, 109 A.2d 523, 530 (1954). Deprivation of family and community life, however brief and necessary, is inevitably traumatic for both younger children and adolescents.[13] Commitment destroys the "continuity of relationships, surroundings and environmental influences [which] are essential for a child's normal development."[14] Moreover, the committed child is placed in an environment characterized by constant staff turnovers, thus making it difficult if not impossible for him to develop new stable relationships. Dr. Eli C. Messinger described the impact of this dislocation on Plaintiff J.L. as follows:

> "One of the things that I noticed about Joey is that he was—he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also,

[13] *See, e.g.,* M. Grob & J. Singer, Adolescent Patients in Transition 115 (1974) [hereinafter Grob & Singer]. A survey of adolescents who had been institutionalized in a private facility of high quality showed that a majority of their families "had a negative view" of the hospitalization. They cited as "added problems which accrued from hospitalization . . . exposure to other sick people, drugs, sex, removal from the community of normal adolescents" and the fact that "the child had irretrievably lost an entire stage of his development." *Id.* at 126, 116.

[14] J. Goldstein, A. Freud and A. Solnit, Beyond the Best Interests of the Child 21 (1973).

> one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey." [15]

Although the potential for grave harm exists when a child is institutionalized for even short periods of time, lengthy institutionalization is particularly deleterious to the maintenance of family ties. It often signifies—or else leads to—formal severance of parental involvement. After the child has been away from home for a substantial period, the "parents have sort of fallen out of love with him" and reintegration into the realigned family circle becomes more difficult.[16] In many cases, admission to a mental institution amounts to a life sentence. According to the Joint Commission on the Mental Health of Children, one-fourth of the children admitted to one state's mental hospitals "can anticipate being permanently hospitalized for the next fifty years of their lives."[17]

Children are particularly adaptable to their environment. These adaptations usually become an integral part of the child's personality. "A child institutionalized for long periods of time may learn and assimilate

[15] A. 211-212.

[16] DeMyer, *New Approaches to the Treatment of Very Young Schizophrenic Children,* in The Mental Health of the Child, 424 (Public Health Service Publication No. 2168, 1971). *See also* Hammond, *Parental Interest in Institutionalized Children: A Survey,* 20 Hosp. & Comm. Psychiatry 338 (1969).

[17] Joint Commission on the Mental Health of Children, Crisis in Child Mental Health: Challenge for the 1970's at 6 (1969) [hereinafter Joint Commission Report].

'institutionally appropriate' behavior, which in turn is . . . [a] handicap if he is to return to his normal environment." [18]

There is, therefore, a definite threat to an institutionalized child of losing his place in and his capacity to adjust to his family and community.

2. Institutionalization Threatens the Intellectual and Emotional Development of Children.

It is widely recognized that institutionalization presents the threat of deleterious long-term effects on cognitive, emotional and social development.[19] Indeed, confinement in an institution frequently produces what is known as "institutional neurosis," a condition characterized by apathy, lack of initiative, loss of individuality and a deterioration in personal habits.[20]

To develop normally, a child must undergo certain basic life experiences at particular stages of his development. For very young children, there is an overwhelming need for a consistent, affectionate "mothering" relationship with one person. Without adequate "mothering," the child never learns to form close personal relationships or to develop inner self controls. As the child grows, he needs individualized responses

[18] Report of the Study Commission on Mental Health Services for Children and Youth at 6 (1973) (A. 904) [hereinafter Georgia Commission Report].

[19] For these reasons many professional child care workers have a "pervasive feeling" that institutionalization should be a last resort. R. Glasscote *et al.*, 35, Children and Mental Health Centers 20 (1972); Joint Commission Report, *supra*, at 269.

[20] R. Barton, Institutional Neurosis (1959) as cited in D. Vail, Dehumanization and the Institutional Career 140-144 (1966).

and guidance in his attempts to master physical, social and intellectual skills. If he is not responded to promptly and positively, he will not continue to strive for mastery of these skills and he may suffer emotional disturbance.[21] A growing child also needs a "wide range of experiences in seeing, hearing, touching, handling and moving" or he will not learn to talk, to develop his intellectual skills or to master conceptualization and abstraction.[22] Further, the preadolescent child needs an increasing involvement with the community, outside of his immediate family environment, if he is to learn to function as a constructive member of society.[23]

In view of these developmental needs, it is significant that studies of young children in institutions document the conclusion that "most infants living in institutions do not get enough mothering in purely quantitative terms." Infant care is typically routinized, the baby "is fed, diapered, lifted up and put to sleep on a schedule that is almost exclusively externally determined." The mother-child communications that form the infant's earliest and often most decisive learning experiences are "reduced to a minimum." [24]

In most institutions there are several different "shifts" of staff each day and the rate of staff turnover is extremely high. In one facility studied, the

[21] J. Bowlby, Child Care and the Growth of Love 60-61 (1953) [hereinafter Bowlby].

[22] Joint Commission Report, *supra* at 321.

[23] Joint Commission Report, *supra*, at 331.

[24] S. Provence & R. Lipton, Infants in Institutions 19 (1962) [hereinafter Provence & Lipton].

children on one ward were cared for by 246 different adults in a three and one-half year period.[25] Under these circumstances consistent "mothering" is an impossibility.

Such deprivation is not limited to infants. Other children as well seldom, if ever, receive the individualized response they need for their experimental forays into physical and mental skill development.

> "The most serious deficiency of the total [institutional] program is the lack of awareness that each child is an individual . . . . The children are herded in groups from one place to another and no opportunity arises for them to be treated as individuals. Individual treatment is, of course, essential for a child to grow into a socially sensitive person."[26]

As one research team observed, "[A]ny attempt to make a personal decision such as is typical of normal childhood will probably cause the individual to be punished because he is deviating from administrative routine."[27]

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[25] N. Hobbs, The Futures of Children 129 (1975) [hereinafter Hobbs].

[26] B. Flint, The Child and the Institution 16 (1966).

[27] H. Leland & D. Smith, Mental Retardation: Present and Future Perspectives 84 (1974) [hereinafter Leland & Smith]; Bowlby, *supra*, at 61:

> "The child is not encouraged to individual activity because it is a nuisance; it is easier if he stays put and does what he is told . . . often the children sit inert or rock themselves for hours together . . . . In these conditions, the child has no opportunity of learning and practising functions which are as basic to living as walking and talking."

Children in institutions are also unlikely to be exposed to the stimuli and challenges a growing child needs. They are often confined to one indoor living unit and one daily period of outdoor recreation. "Nothing is new, nothing is different, therefore nothing is memorable. Life is dull and plodding; an interminable sequence of sameness over and over again."[28]

Finally, life in an institution rarely offers opportunity for integration of a child into community life. The family is the usual "socializing agent" and bridge to community life. Children of a very young age develop marked identification with their kinfolk which assists them in finding a community identity.[29] When they are denied community experiences and involvement, "their behavior as young adults reflects their lack of contact with normal people during their developmental period." Institutionalized children "have as models only other handicapped persons."[30]

There has been extensive documentation of the psychological and developmental harms that beset an institutionalized child or adolescent. These include low scores on intelligence tests, poor progress in school, deficiencies in emotional and social development. These harms accelerate with the length of the institutionalization, the age at which the child was first admitted

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[28] B. Flint, *supra*, at 15.

[29] Elkin, *Agents of Socialization*, in Children's Behavior 360 (Bergman ed. 1968).

[30] Leland & Smith, *supra*, at 86; Glenn, *The Least Restrictive Alternative in Residential Care and the Principle of Normalization*, in The Mentally Retarded Citizen and the Law, (M. Kindred, *et al.*, eds. 1976).

and the impoverished conditions in the institution.[31] Institutionalized infants show marked retardation in intellectual and language development.[32] Moreover, this retardation does not readily disappear even when the infants are placed in foster homes before the age of two.[33] This phenomenon applies to well-staffed nurseries as well as to poorly run state hospitals. "[T]he residential nursery considered as a language laboratory appears to be inferior to a 'good' working-class home."[34]

The harms of institutionalization extend to social and emotional as well as cognitive development. Institutionalized children tend to become "apathetic"[35] and unable to form meaningful relationships with others, or they acquire "affection hunger" characterized by "incessant and insatiable seeking of affection."[36] This

[31] Hobbs, *supra* at 135, 142-143. Of course, in recent years, mental health and mental retardation professionals have learned more about how, given adequate resources, institutions can have more effective habilitation programs. Possibly, in the relatively few institutions which now have such adequate habilitation programs, children would not show such impaired development relative to children who are not institutionalized. Unfortunately, such comparative information is not currently available.

[32] Yarrow, *Maternal Deprivation: Toward an Empirical and Conceptual Reevaluation in Maternal Deprivation* 3, 9-11 (Child Welfare League of America, 1962).

[33] Provence & Lipton, *supra* at 149, 155-156.

[34] Tizard & Joseph, *Cognitive Development of Young Children in Residential Care: A Study of Children Aged Twenty-Four Months*, 11 J. Child Psychology-Psychiatry 177, 185 (1970). *See also* Lagmeir & Matejcek, *Mental Development of Children in Families and in Infant Homes*, 4 Soc. Sci. & Med. 569, 570-573 (1970).

[35] Hobbs, *supra*, at 143.

[36] Yarrow, *supra* at 14.

emotional and social lag, like its cognitive counterpart, typically persists even after the institutionalized infant is removed to a family environment.[37]

It is for these reasons that professionals in the mental health field caution against the institutionalization of a child except when it is absolutely necessary.[38]

The inherent dangers of institutionalization are, moreover, exacerbated for many children because they are placed in substandard institutions, lacking adequate staff, physical facilities and constructive programs designed to improve or cure the child's underlying condition. In 1969 the Joint Commission on the Mental Health of Children[39] reported that "most"

[37] Provence & Lipton, *supra* at 150-155. *See also* Youngleson, *The Need to Affiliate and Self-Esteem in Institutionalized Children*, 26 J. Personality and Soc. Psychology 280 (1973); Tizard & Rees, *The Effect of Early Institutional Rearing on the Behavior Problems and Affectional Relationships of Four-Year-Old Children*, 16 J. Child Psychology-Psychiatry 61 (1975).

[38] "[N]o matter how good a treatment program for children in the state hospital is, hospitalization of an emotionally disturbed child is not the best answer."

The "basic experiences which a child needs in order to grow into an emotionally happy, healthy and productive adult . . . cannot be found in a hospital."

Reiger, *Changing Concepts in Treating Children in a State Mental Hospital*, 1 Int. J. Child Psychotherapy 89, 104, 107 (1972).

"It makes little difference whether the institution is called hospital or school, whether it is supposedly medically oriented or educationally oriented; in either case the child is trained to live in an institutional setting, and thus learns many of the very things that we do not want him to learn."

Leland & Smith, *supra*, at 87.

[39] The Joint Commission on the Mental Health of Children was established by the U.S. Department of Health, Education and Welfare pursuant to amendments to the Social Security Act, July 30,

mental institutions for children are "disgraceful and intolerable." Each year thousands of minors are removed from their homes, schools and communities and confined to hospital wards with psychotic adults or to depersonalized institutions which deliver little more than custodial care. As the Joint Commission stated:

> "Each year, increasing numbers of [children] are expelled from the community and confined in large state hospitals so unde.. 'affed that they have few, if any, professionals trained in child psychiatry and related disciplines.
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> "In most of these hospitals the usual practice is to place the youngsters in wards with adult patients, frequently with those who are in an advanced stage of mental deterioration. These children and youth receive little, if any, therapeutic care, and no provision is made for the continuation of their education. An imprecisely determined number are left to 'rot on the back wards,' condemned to a hopeless life of continuing institutionalization." [40]

In addition to shortages of professional staff, the Commission found untrained attendants, failure to provide

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1965, Pub. L. 89-97, § 231(a)-(d), 79 Stat. 360. It was composed of "representatives of leading national medical, welfare, educational, and other professional associations, organizations, and agencies active in the field of mental health of children." *Id.* § 231(c).

[40] Joint Commission Report, *supra*, at 5 and 269. *Cf. Jackson* v. *Indiana*, 406 U.S. 715, 734-735 n. 17 (1972): "[There are] substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *See also* A. Stone, Mental Health and Law: A System in Transition 21 (1975) ("As one considers the entire law-mental health system, its most tragic faults are to be found in what it does to the young.").

education and recreation and "outmoded facilities" operating on "long abandoned theory," and it concluded pessimistically that "instead of being helped, the vast majority [of children] are the worse for the experience." [41]

Unfortunately, the institutions to which the plaintiffs have been committed are characterized by these same conditions. In 1973, a Study Commission on Mental Health Services for Children and Youth was formed in Georgia. After six months of study of the then five regional hospitals the Commission reported "that State improvement of mental health services to children and youth is *urgently needed.*" (emphasis added) The Commission found that [42]

> "[in] many cases, youth are housed on geographic units with disturbed adults. Staff were concerned that in these units adolescents are continuously confronted with pathological adult behavior patterns at a time in their psychological development when healthy role models are needed to help them develop an individual sense of identity." [43]

The Commission cited a range of problem areas which are statewide in nature.[44]

The Commission urged the development of appropriate and adequate services based upon professional standards, and a State plan, developed with citizen advisory participation, reflecting unmet needs of children and youth. They reported there were no estab-

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[41] *Id.* at 6.

[42] Georgia Commission Report at 9 (A. 906).

[43] *Id.* at c-1.

[44] A. 902.

lished State program standards, no State plan for mental health services to children and youth and few appropriate services both within and without institutions." As the district court found, conditions have not changed since the Commission's report. J.S. 52a.

Given these facts it is not surprising that five of the eight regional hospitals to which children are confined in the State of Georgia have been denied accreditation by the Joint Commission on Accreditation of Hospitals (JCAH)." The poor quality of mental facilities available for children both in Georgia and in the country at large only serves to underscore the enormous harm to a child that results from an erroneous decision to commit.

3. Institutionalization Stigmatizes a Child Thereby Causing Him Future Harm.

The adverse effects of commitment do not end when the child is finally released from the institution. Both the record in this case and the professional literature demonstrate the profound stigma associated with being labeled "mentally ill."

> "[B]eing an ex-mental patient is more of a liability than being an ex-criminal in the pursuit of housing, jobs, and friends. Mental patients have for years been regarded with more distaste and less

" A. 906.

" Testimony of Dr. Douglas Skelton (A. 221, 228). JCAH is a private body which inspects a wide range of medical treatment facilities and certifies them according to professionally accepted standards. JCAH, *Accreditation Manual for Psychiatric Facilities Serving Children and Adolescents* iii (1974).

" Testimony of Dr. Eli Messinger, (A. 177).

> sympathy than virtually any other disabled group in our society. . . ." "

Former mental patients also suffer discrimination in admission into higher education," military and government services and in applications for licenses and health insurance."

" Rabkin, *Public Attitudes Toward Mental Illness: A Review of the Literature*, Schizophrenia Bulletin at 10 (Issue #10, Fall 1974). *See also*, Tringo, *The Heirarchy of Preference Toward Disability Groups*, 4 Journal of Special Education 295 (1970), where it was found that of 21 disability groups including exconvicts and alcoholics, the mentally ill ranked lowest in public esteem; J. Nunnally, Popular Conceptions of Mental Health: Their Development and Change 42-51 (1961). It is important to note that the general public associates mental illness with the fact of hospitalization, but does not attach this label to less drastic forms of psychiatric or psychological therapy. *See* Goffman, *Career of the Mental Patient*, 22 Psychiatry: Journal for the Study of Interpersonal Processes 123 (May 1959); Johannsen, *Attitudes Toward Mental Patients: A Review of Empirical Research*, 53 Mental Hygiene 218 (1969); Phillips, *Public Identification and Acceptance of the Mentally Ill*, 56 American Journal of Public Health 755 (1966).

" This Court has already acknowledged that short-term suspensions of children from school "could seriously damage the students' standing with their fellow pupils and their teachers as well as interfere with later opportunities for higher education and employment." *See also, In re Gault*, 387 U.S. 1, 23, 24 (1967). Former Secretary of the Department of Health, Education and Welfare, Elliot Richardson, has declared that "inappropriate labelling of children as *delinquent, retarded, hyperkinetic, mentally ill, emotionally disturbed* . . . has serious consequences for the child." Hobbs, *supra*, Preface at ix.

" *See*, American Psychiatric Association, Task Force Report 9, Confidentiality and Third Parties 27, 53-59 (1975) ("Attitudes of a large part of our social world are still prejudicial and the livelihood and social well-being of some of our patients can be threatened in reality by . . . disclosures"; rejection by school systems and many government agencies of those with psychiatric histories; use

A record of institutionalization produces negative expectations in those with whom the ex-patient later comes into contact, including teachers and prospective employers." The evidence also suggests that persons with mental disturbances suffer greater rejection from their peers if they seek help in an inpatient psychiatric residence, rather than from a clergyman or a physician or on a psychiatric outpatient basis." Institutionalization in a mental facility may also produce a negative

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of psychiatric information in school records to the detriment of the child). N. Spingarn, Confidentiality, A Report of the 1974 Conference on Confidentiality of Health Records 5 (American Psychiatric Association 1975) (graduate school rejection on basis of a student's history of emotional problems). *See also* The Mentally Retarded Citizen and the Law, *supra*, chs. 6, 8, 10, 11.

There is also evidence that, once hospitalized, a mental patient is more likely in the future to be differentially diagnosed as in need of rehospitalization.

> "Physicians responsible for hospitalization seem, unwittingly, to take this history into account, independent of the number of symptoms and apparently even the severity of the patient's present illness."

Roth, *Some Comments on Labelling*, Bulletin of the American Academy of Psychiatry and the Law (1976) citing Mendel & Rapport, *Determinants of the Decision for Psychiatric Hospitalization*, 20 Arch. Gen. Psychiatry 321 (1969).

" *See* Whatley, *Social Attitudes Toward Discharged Mental Patients*, in The Mental Patient: Studies in the Sociology of Deviance 401 (1968). Because of a "lingering social stigma attached to newly discharged patients . . . their social relations are often characterized by social distance, distrust or denial of employment." *See also* Grob & Singer, *supra*, at 117.

" Phillips, *Rejection: A Possible Consequence of Seeking Help for Mental Disorders*, in Mental Illness and Social Processes 63 (T. Scheff ed. 1967).

self-image in the child." Frequently a formerly committed individual tends to perceive society's negative response to him as a valid measure of his personal worth. The label becomes a "double-edged blade," causing "him to demean himself and to magnify social ostracism." *In re Ballay*, 482 F.2d 648, 669 (D.C. Cir. 1973)."

In the case of a child who is actually in need of commitment to a mental institution, these detrimental effects are the unfortunate price that must be paid to enable the child to overcome his disability. But, where a child is committed unnecessarily, the profound and long-term harm that results is inexcusable.

B. There Is a Substantial Risk of Error in Decisions to Commit Children to Mental Institutions.

1. THE DECISION TO INSTITUTIONALIZE IS OFTEN MADE ON THE BASIS OF CONFLICTS OF INTEREST BETWEEN THE CHILD AND OTHER FAMILY MEMBERS OR IN IGNORANCE OF THE AVAILABILITY OF ALTERNATIVE RESOURCES.

The manner in which decisions to institutionalize children are made must provide assurances that the child's interest in remaining in the mainstream of family and community life and avoiding developmen-

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" One study which interviewed 110 mildly retarded former institutional residents found:

> "All persons interviewed said that their former status had burdened them with a shattering stigma and that they were forced to create elaborate ways of evading recurrent social ostracism—for instance, by rejecting as false the initial diagnosis and inventing ingenious ways to cover real deficiencies."

I Issues in the Classification of Children 214 (N. Hobbs ed. 1975).

" *See also* Cumming and Cumming, *On the Stigma of Mental Illness*, 1 Community Mental Health Journal 135, 136 (1965).

tal harms is protected. Institutionalization for mental illness is not, as appellants argue,[48] primarily a medical decision in which parents' interests can be assumed to be in harmony with the children's interest.[49] Rather, too often the decision is based on whether the child's family has sufficient emotional and financial resources to cope with the child's behavior at home and whether the community has sufficient tolerance for his behavior or resources to offer the family as an alternative to institutionalization.[50]

Testimony in the court below emphasized that the mentally ill child's problems are "inextricably re-

[48] Appellants' brief at 14 and 15.

[49] *Cf. Planned Parenthood of Cent. Mo.* v. *Danforth*, 428 U.S. 52, 103, 104 (1976). (Stevens, J. concurring in part and dissenting in part). Justice Stevens referred to the fact that "the most significant consequences of the decision [to abort] are not medical in character . . . . In each individual case factors much more profound than a mere medical judgment may weigh heavily in the scales. The overriding consideration is that the right to make the choice be exercised as wisely as possible."

[50] *See, e.g.*, Lindsey, *Adolescent Pathways to Residential Treatment: The Enforced Expedition*, suggesting that "rather than performing an illness-reduction service, mental hospitals alleviate community and family displeasures through an annoyance-reduction service." *Id.* at 136. The study showed that most adolescent admissions into a public mental hospital resulted from "unmanageable" or "inappropriate" behavior as defined by police, community members or family. *Id.* at 140. The author concluded, "[F]or most of these adolescents the prescription of residential placement is more often the result of a response on the part of social agencies in the adolescent's social world than by the specific nature of the behaviors performed by the adolescent." *Id.* at 143. He warned that "mental illness is distinctly different from physical illness. Mental illness is not just an adolescent's private troubles and personal problem. Rather, it is a label applied to the alleged and inappropriate behavior engaged in by the adolescent. The conflictive nature of this behavior emerges from an analysis of the social environment of the prepatient adolescent." *Id.* at 144.

lated" to the pathology of the family.[51] Some children unwittingly become the "scapegoats" for family hostilities; some parents have hidden agendas and even unconscious motivations for institutionalizing the child. A parent may be mentally ill or under severe psychological stress himself, projecting his own illness onto the child.[52] The Joint Commission Report accurately acknowledged "growing recognition that a child's emotional disturbance is frequently . . . associated with the complex and intricate interpersonal relations within the family and the interactions that the family has with the larger social system."[53]

The motives of parents in deciding on institutionalization for a mentally ill child are not necessarily blameworthy; they may simply reflect priorities for family survival,[54] such as the interests of other children in the family, the mental and physical frustration of the parents, economic strain resulting from the care of the child, the stigma of the handicap itself, or hostility toward the child caused by fatigue and frustration of the parents' success-oriented expectations for the child.[55] But, as the court below and other courts have

[51] Testimony of Dr. Eli Messinger, (A. 163).

[52] Testimony of Dr. Eli Messinger, (A. 163-165), testimony of Dr. Luciano L'Abate, (A. 804-806).

[53] Joint Commission Report, *supra*, at 263.

[54] Grob and Singer, *supra*, at 122 (followup interview of institutionalized minors and their families showed that virtually no parents perceived the hospitalization as resulting in a cure of the child's problems. "Most parents did see the hospitalization serving an ameliorative function, *e.g.*, releasing them of responsibility and of home tensions, and protection of the patient and/or society.")

[55] Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Lawyer 139-143 (1972).

recognized, these interests compete with those of the institutionalized child."

Institutionalization decisions have been shown to relate more closely to the characteristics of the family than to the severity of the child's condition or to the optimum treatment. Children from broken homes, from homes with substandard incomes, from homes with other physically or mentally ill persons present are disproportionately represented in the institutional population."

Thus, the decision by parents to place their children in a mental institution is too often a decision made in default of knowledge about community-based alternative services and, for complex reasons, unrelated to

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"*See e.g., Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville* v. *Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *In re Long*, 25 N.C. App. 702, *cert. denied*, 288 N.C. 241 (1975).

"G. Saenger, Factors Influencing the Institutionalization of Mentally Retarded Individuals in New York City 13 (Report to the New York State Interdepartmental Health Resources Board, 1960), 11, 84 (44% noninstitutionalized versus 77% institutionalized children come from broken homes); D. Block & M. Behrens, A Study of Children Referred for Residential Treatment in New York State 43 (Report to the New York State Interdepartmental Health Resources Board 1959) 32-35 (half of institutionalized children came from multiproblem families, half had mentally ill family members); Appell & Tideall, *Factors Differentiating Institutionalized from Non-Institutionalized Referred Retardates*, 73 Am. J. Men. Def. 424, 429 (1968) (37% institutionalized children versus 14% noninstitutionalized children from broken homes; 62% institutionalized versus 22% noninstitutionalized children from impoverished homes). *See also* J.S. 20a., where the opinion of the district court indicated that 50-75% of the children in Georgia mental institutions had no family or were part of "severely dysfunctional" family units.

the best interests of their children." Because the risk of unnecessary confinement of the child is extremely high, such commitments must be accompanied by procedural safeguards designed to ensure the appropriateness of commitment.

2. There Is a Substantial Risk of Error in Recommendations by Mental Health Professionals to Confine Children to Institutions.

Despite the enormous harm to the child that results from an erroneous decision to commit, due process might not require an evidentiary hearing if the likelihood of psychiatric error was relatively slight. In fact, however, there is a very substantial risk of error in recommendations and decisions to confine children to mental institutions.

a. *There Is a Tendency by Mental Health Professionals to Overinstitutionalize Children.*

The tendency of mental health professionals to prescribe institutionalization for persons not in need of

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"*Cf.* Child Caring: Social Policy and the Institution 112 (D. Pappenfort, et al., eds. 1973):

> "[O]ne thing that is clear from a variety of statistical data is that both the decision to place a child in an institution and the selection of the type of institution for him are dependent to a great extent on factors other than the needs of the child."

See also R. Glasscote, *supra*, at 973, quoting psychiatric program personnel who decided between inpatient and outpatient admissions:

> "Diagnosis itself has minor significance . . . . Rather we look to the criteria of the child's daily living situation at home."

confinement has been widely noted.[66] Various empirical studies have verified it.[67]

Various factors explain the predisposition of mental health professionals to recommend institutionalization where it is not required. First, the tradition of the medical profession dictates erring on the side of ap-

[66] *See, e.g.*, T. Scheff, *Being Mentally Ill: A Sociological Theory* 105-21 (1966); Bazelon, *Institutionalization, Deinstitutionalization and the Adversary Process*, 75 Colum. L. Rev. 897, 900 (1975); Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, 4 Trial 29, 32-33 (Feb./March 1968); Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 Calif. L. Rev. 840, 863-68 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 711-19 (1974); Livermore, Malmquist and Meehl, *On the Justifications for Civil Commitment*, 117 U. Pa. L. Rev. 75, 83-84 (1968); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations in the Prediction of Infrequent Events*, 18 J. of Con. Psychology 397 (1954); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 Yale L. J. 1540, 1553-54 (1975); *People* v. *Burnick*, 14 Cal. 3d 306 (1975); *In re Long*, 25 N.C. App. 702, *cert. denied*, 288 N.C. 241 (1975); Deposition of Dr. Eli Messinger, (A. 171-173).

[67] *See, e.g.*, Rappeport, Lassen and Gruenwald, *Evaluation and Followup of State Hospital Patients Who Had Sanity Hearings*, 118 Am. J. Psychiat. 1078 (1962). The authors studied the progress of 38 persons who obtained release from a state mental institution over the objection of the institution's psychiatrists. After a year or more, nearly half of the 38 had made a satisfactory adjustment to the community, i.e., they had not been rehospitalized, had not been in serious trouble with the law, and were caring for themselves.

See also, Hunt and Wiley, *Operation Baxstrom After One Year*, 124 Am. J. Psychiat. 974 (1968). This followup study conducted after this Court's decision in *Baxstrom* v. *Herold*, 383 U.S. 107 (1966), followed 969 patients who had been detained in maximum security hospitals by the New York Department of Corrections because psychiatrists had determined them to be mentally ill and too dangerous for release or even for transfer to civil hospitals.

parent caution.[68] The profession perceives the consequences of not treating an individual for a suspected illness as being more serious than the consequences of unnecessary treatment. In the case of mental illness the result of undue "caution" can be devastating—unnecessary confinement in a mental institution.

Second, psychiatrists tend to think in terms of psychopathology.[69] They are apt to diagnose mental illness from ambiguous behavior rather than recognizing equally plausible, yet non-pathological explanations for that behavior.[70] An example of finding psychosis where none exists was reported in the study by David Rosenhan.[71] In Dr. Rosenhan's study, eight normal persons presented themselves for voluntary admission at twelve different mental institutions. The only symptom the subjects pretended to exhibit was hearing voices. Beyond this, they acted normally and were truthful in describing themselves and their history. In every instance, the subject was admitted to the hospital with a diagnosis of schizophrenic or manic-depressive psychosis.

Within a year after their transfer to civil hospitals, 147 had been discharged to the community and only 7 had to be recommitted to a prison hospital; Steadman and Keveles, Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70, 129 Am. J. Psychiat. 304 (1972).

[68] *See* T. Scheff, *supra*, at 105-21; Ellis, *supra*, at 865-66; Rosenhan, *On Being Sane in Insane Places*, 13 Santa Clara L. Rev. 379, 385 (1973).

[69] S. Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior*, 53 Mental Hygiene 21, 26 (1969).

[70] Kumaska and Gupta, *Lawyers and Psychiatrists in the Court: Issues in Civil Commitment*, 32 Md. L. Rev. 6, 34 (1972).

[71] D. Rosenhan, *supra*, n. 68.

Rosenhan described one of his subjects as having

> "had a close relationship with his mother but was rather remote from his father during early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relationship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked." [72]

But on the basis of the same information the case summary prepared by the institution portrayed a mentally ill individual:

> "This white 39 year-old male . . . manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of children, spankings. And while he says that he has several good friends, one senses considerable ambivalence embedded in those relationships also . . . ."

Third, erroneous decisions *not* to admit a child are more likely to come to the attention of mental health professionals than erroneous decisions *to* admit. When an individual is erroneously committed, subsequent "normal" behavior will be attributed to the positive effects of institutionalization rather than to a mistaken commitment. On the other hand, when an individual is mistakenly released, that error is likely to come to the

[72] *Id.* at 387.

attention of the admitting psychiatrist when, as sometimes occurs, the person is referred again for possible commitment. In sum, mental health professionals become aware of their mistakes only when they deny admission, and this further inclines them to a decision to admit in future doubtful cases."[73]

Fourth, by erring on the side of institutionalization rather than outpatient care, the mental health professional avoids the possibility that he or the institution will be held responsible, or even liable, if the child should cause harm to himself or others after institutionalization has been denied."[74] There is no comparable risk in the case of mistaken commitments."[75]

Fifth, institutional personnel have knowledge of and confidence in the benefits of institutionalization, while minimizing some of its potential harms. Moreover, they frequently lack knowledge of the availability and desirability of community-based facilities or other possible outpatient alternatives. Familiarity with just one mode of treatment increases the likelihood of a recommendation of admission.

Finally, mental health professionals are frequently influenced by the admission policies of their institution. In the mental health field, more often than in general medicine, it is institutional policy rather than clinical

[73] A. Dershowitz, *supra*, at 32-33; Note, *The Role of Counsel in the Civil Commitment Process*, *supra*, at 1554.

[74] *Cf. Hicks* v. *United States*, 511 F.2d 407 (D.C. Cir. 1975); *Underwood* v. *United States*, 356 F.2d 92 (5th Cir. 1966); *Fair* v. *United States*, 234 F.2d 288 (5th Cir. 1956).

[75] *See* A. Dershowitz, *supra*, at 32-33; Bazelon, *supra*, at 400; Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, *supra*, at 1554.

necessity that determines which children will be admitted and what treatment will be offered."

b. *Psychiatric Diagnoses Are Unreliable*

Appellants assert that there exists a high degree of reliability in psychiatric diagnoses." They contend that there is little evidence that psychiatry is an "inexact science." " Their contentions are incorrect. As the Chief Justice recently pointed out in *O'Connor* v. *Donaldson,* 422 U.S. 563, 584 (1975) (concurring opinion), "There can be little responsible debate regarding the uncertainty of diagnosis in this field and the tentativeness of professional judgment." Another court found,

> "Psychiatrists themselves would be the first to admit that however desirable an infallible crystal ball might be, it is not among the tools of their profession. It must be conceded that psychiatrists still experience considerable difficulty in confidently and accurately diagnosing mental illness."

People v. *Burnick,* 14 Cal.3d 306, 326-27 (1975)."

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[76] Richman and Pinsker, *Utilization Review of Psychiatric Inpatient Care,* 130 Am.J.Psychiatry 900, 901 (1973). *See also* Mendel and Rapport, *Determinants of the Decision for Psychiatric Hospitalization,* 20 Arch.Gen.Psychiatry 321 (1969); Rabiner, *et al., The Assessment of Individual Coping Capacities in a Group Therapy Setting,* 45 Am. J. Ortho. 399 (1975) ("few clinical decisions in psychiatry are as difficult to make as those involving hospitalization.").

[77] Brief for Appellants at 19.

[78] *Id.* at 18.

[79] *See also,* testimony of Dr. Luciano L'Abate:

> "I am perfectly aware of the fallibility of our diagnostic labels, our own diagnostic tests, and in many cases our tests that we use in clinical psychology are not better than the criteria we use, which are mostly psychiatric diagnosis, and [I] realize

It is clear that diagnosis of mental illness is an area of uncertainty and consequent high risk of error.

c. *Decisions to Confine Children to Mental Institutions Are Frequently Made Without Adequate Information or Adequate Exposure to the Child.*

In the context of evaluating children whose commitment to a mental institution is proposed, the likelihood of error is exacerbated by the paucity of information on which commitment decisions are frequently based.

A mental health professional should have as much knowledge as possible of a child's situation in order to decide whether to institutionalize the child.[80] The reason for this is that a child is likely to experience deep anxiety at the first clinical interview and is therefore unlikely to place in the mental health professional the trust and confidence required for a successful evaluation.[81] In addition, children often experience great fluctuations in behavior over short periods of time,

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> that any time we have that kind of criteria in our tests they are really not very good."

(A. 805, 806). *See also, In Re Ballay,* 482 F.2d 648, 665 (D.C. Cir. 1973); Ennis and Litwack, *supra,* at 719. *Cf. Blocker* v. *United States,* 288 F.2d 853, 869, n. 28 (D.C. Cir. 1961) (Burger, J., concurring).

[80] S. Chess, An Introduction to Child Psychiatry 47 (2nd ed. 1974); Group for the Advancement of Psychiatry, *The Diagnostic Process in Child Psychiatry,* 313 in 3 Reports and Symposiums, Report No. 38 (1957); T. Scheff, *supra,* at 174. The Menninger Foundation recommends that evaluation be conducted by a team of specialists rather than by a lone psychiatrist. The Menninger Foundation Children's Division, *Disturbed Children: Examination and Assessment Through Team Process* (1969).

[81] J. Simmons, Psychiatric Examination of Children 1 (2nd ed. 1974); Group for the Advancement of Psychiatry, Report No. 38, *supra,* at 338-42.

particularly in different settings. Adolescence is normally a time of emotional turmoil, behavioral excesses and rapid change. One can expect alterations and fluctuations in behavior."

Psychiatric or psychological judgments on children whose commitment is sought, however, are typically based on a single interview in a strange setting under abnormal stress. In such instances, the mental health professional will have difficulty in gaining the child's confidence and may indeed be hostilely perceived as an agent of the parents; he will rarely be able to make a thorough evaluation or prediction of the child's future behavior from such an interview."

Moreover, confinement decisions are based, to a considerable extent, upon information provided by the same parents who are seeking commitment of their children. In fact, such information may be the single most important source of data provided to evaluating professionals." And it appears that mental health

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" *See* Ennis and Litwack, *supra*, at 723-24; T. Scheff, *supra*, at 174.

" *See*, Lourie & Rieger, *Psychiatric and Psychological Examination of Children*, in 2 American Handbook of Psychiatry 19 (S. Arieti ed. 1974).

> "From the child's viewpoint, his degree of cooperation with the examiner will be very different if he feels the examiner is a benevolent adult, interested in his side of any reported troubles and understanding of his worries, as against his perception of a demanding, punitive, authoritative figure who has the power to recommend significant changes in his way of life . . . . His approach to the examination may limit the amount of information available to the examiner, or obscure his assets and conflict-free areas of functioning, or give a distorted picture of his functioning in other situations."

" A. 167.

professionals tend to believe parents' accounts of deviant behavior of their children even if those accounts are inconsistent with their direct observations of the child."

In light of the conflicts of interest between the child and other members of the family and the unreliability of diagnostic techniques, there is a serious risk of error in the Georgia "voluntary" commitment process. This risk of error, coupled with the grave and irreversible harm that can result from an erroneous decision to institutionalize, requires an evidentiary hearing, the nature of which will be explored in Section III, *infra*.

C. The Countervailing Interests of the State Do Not Outweigh the Child's Need for an Evidentiary Hearing.

1. The Interest of the State Acting as Guardian for the Child Does Not Outweigh the Child's Need for an Evidentiary Hearing.

Initially, it is important to emphasize that in many cases there is no parent involved in the decision to commit a child. As the court below found, parental consent for the commitment is provided, in these cases, by the state welfare department acting as guardian or standing *in loco parentis* to the child."

When a child is placed in a mental facility by a state guardian rather than by parents, the constitutionally protected interests of family autonomy are not relevant. The situation is indistinguishable from cases in which the state initiates involuntary commitment proceedings against adults or children. *Cf. In re Gault*,

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" A. 168.

" J.S. 5a, 6a, 39a.

387 U.S. 1 (1967)." And the threats of harm to institutionalized state wards are, if anything, greater than to children admitted by natural parents. State wards are denied both the oversight of natural parents as to their treatment inside the institution and the bridge of their family to the normal world outside the institution. They tend to remain in hospitals longer due to the pervasive lack of adequate community facilities to treat and house them on discharge."

As Dr. John P. Filley, Director of the Office of Child and Adolescent Mental Health Services, testified: "The [welfare department] takes the child to the hospital and says, 'Now, it's off our hands.' They're beseiged with oversized case loads and so on. . . ."

Therefore a state agency should not be permitted to authorize commitment of a child to a mental institution without the check provided by a hearing procedure.

" State involuntary commitment statutes which require evidentiary hearings can be invoked against children as well as adults. The state may also invoke neglect jurisdiction when it believes that a parent is unjustifiably withholding needed psychiatric treatment from his child. Neglect proceedings, of course, would require a hearing in which the parents (and usually the child) can contest the need for residential treatment.

" One of the named plaintiffs in the present case had been in seven foster homes as a neglected child; at age eight he was placed in the state mental hospital. He remained there for five years despite official predictions that he "will only regress if he does not get a suitable home placement, and as soon as possible." (J. S. 6a). *See also*, D. Block & M. Behrens, *supra*, at 16-17, 32-35 (40% of institutionalized children had lived in four or more different homes or institutions prior to admission; less than one-fourth were living in their natural homes at the time of admission).

" A. 101.

2. The Interest of the State in Preserving Family Autonomy Does Not Outweigh the Child's Need for an Evidentiary Hearing.

The primary justification offered by the state in support of its "voluntary" commitment statute is the state's interest in preserving family autonomy. However, an evidentiary hearing is not inconsistent with the legitimate interests of parents. Families often feel ambivalent and helpless about an emotionally disturbed child; they are driven to institutionalization because they do not know what else to do, and are genuinely searching for a resolution that will allow their child to remain with them. In *Martin M.* v. *Shephard* (D. Conn. No. H-75-130), for example, a father testified as follows concerning his commitment of his son:

> Q. During the year Michael was [in the Hospital] did you, as his parent feel that it was an appropriate place for him to be?
> A. No way, no way.
> Q. Why not?
> A. The conditions were deplorable.
> . . .
> Q. Why did you sign him in the hospital?
> A. We had no other recourse, none.

Testimony of Mr. Karl K., Transcript at 7."

In contrast to the present system for admissions, an evidentiary hearing would provide parents with an opportunity to explore alternatives to institutionalization which would help to preserve the integrity of the family. *See* pp. 50-51, *infra*.

" *Martin M.* is one of several cases presently pending in the district courts challenging the constitutionality of "voluntary" commitment statutes.

Moreover, as *amici* have noted at p. 31 *supra*, some parents attempt to institutionalize their children for reasons which are not consistent with the best interests of the child, *e.g.*, familial conflict, family priorities or other motives not related to the child's need for institutionalization. In some cases, they act unwittingly; in other cases they do not.

As the court below pointed out:

> "Unfortunately, as the evidence indicates there are some parents who abuse [the] authority [to commit] and who under the guise of admitting a child to a mental hospital actually abandon their child to the state. . . . [S]ome still look upon mental hospitals as a 'dumping ground.'"[43]

The case of J.L. is illustrative. It was stipulated that this child was hospitalized because his mother was concerned that he was adverseiy affecting her relationship with her second husband and their child.[44] Following her consent to J.L.'s commitment, she abandoned him and the institution thereafter was forced to deal with the state welfare agency in matters regarding J. L."[45]

Virtually every lower court that has considered the issue has found that with respect to the commitment of a child, there is a significant chance that parents may be acting against the interests of their children."[46]

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[43] J.S. 50a.

[44] Stipulation of Fact, Exhibit #2-B-2; Mem. Dep. at A. 96.

[45] *Id.*

[46] *See, e.g., Bartley* v. *Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded*, 431 U.S. ——, 45 U.S.L.W. 4451 (1977); *Heryford* v. *Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville* v. *Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974);

Amici acknowledge the special relationship that exists between parent and child. *See, e.g., Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. ——, 45 U.S.L.W. 4638 (1977); *Wisconsin* v. *Yoder*, 406 U.S. 205 (1972); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). Historically, however, limitations on parental authority over the lives of their children have been recognized in the law.[47] And, although parents ordinarily have the primary role in decisions affecting their children, when the interests of the child may conflict with those of the parents, independent representation for the child is required. *See, e.g., Prince* v. *Clark*, 81 Mich. 167, 170-71 (1890). Therefore, courts have often appointed independent guardians for children and have refused to allow parents to donate their children's organs;[48] alienate their chil-

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New York Association for Retarded Children v. *Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973); *Horacek* v. *Exon*, 357 F. Supp. 71, 74 (D. Neb. 1973); *In re Henry G.*, 28 Cal. App. 3d 276, 285 (2nd Dist. 1972); *In re Lewis*, 51 Wash. 2d 193, 200-01 (1957); *In re Hippy*, 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953); *In re Wretlind*, 225 Minn. 554, 561-62 (1948). The Chief Justice has advised of "the need to make civil commitment difficult, recognising the dangers of relatives 'farming' out their kindred into mental institutions for motives not always worthy." *Kent* v. *United States*, 401 F.2d 408, 416 n. 4 (D.C. Cir. 1968) (Burger J., dissenting).

[47] *See generally*, 1 W. Blackstone, Commentaries 452-53, 465-66; J. Story, Commentaries on Equity Jurisprudence, Chapter 34 (1835); J. Woerner, A Treatise On the American Law of Guardianship of Minors and Persons of Unsound Mind § 14 (1897).

[48] *See, e.g., In re Guardianship of Pescinski*, 67 Wis. 2d 4, 226 N.W.2d 180 (1975); *Hart* v. *Brown*, 29 Conn. Sup. 368, 289 A.2d 386 (1972); *Strunk* v. *Strunk*, 445 S.W.2d 145 (Ky. 1969); *In re Richardson*, 284 So.2d 185 (La. App.), *cert denied*, 284 So.2d 338 (S. Ct. La. 1973).

dren's property;" compromise their children's injury claims;[97] withhold essential medical treatment from their children;[98] and authorize the sterilization of their children.'[99]

In *Prince* v. *Massachusetts*, 321 U.S. 158 (1944), this Court pointed out that although "the custody, care and nurture of the child reside first in the parents," parental rights are not "beyond limitation." *Id.* at 166. In *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976), this Court held that a parent may not be granted an absolute veto over the decision of a minor child to secure an abortion. Most significantly, in *Bellotti* v. *Baird*, 428 U.S. 132 (1976), the Court strongly indicated that a statute that permitted a child to obtain judicial approval for an abortion, where parental approval was withheld, would pass constitutional muster. Thus, the Court refused to uphold absolute parental control over a decision vital to the life of a minor, but implied that,

[97] *See generally*, 1 W. Blackstone Commentaries 452-53, 465-66; J. Kent, 4 Commentaries on American Law 185-89 (1830); *see, e.g., Martorell* v. *Ochoa*, 276 F.99 (1st Cir. 1921); *In re Schultz Estate*, 374 P.A. 459, 98 A.2d 176 (1953).

[98] *See, e.g., American Mutual Liability Insurance Co.* v. *Volpe*, 284 F.75 (3rd Cir. 1922); *White* v. *Osborne*, 251 N.C. 56, 110 S.E. 2d 449 (1959); *Loesch* v. *Vassiliades*, 17 N.J. Super. 306, 86 A.2d 14 (1952).

[99] *See, e.g., Jacobson* v. *Massachusetts*, 197 U.S. 11 (1944); *Green Appeal*, 448 Pa. 338, (1972), *appeal after remand*, 452 Pa. 373, (1973); *In Re Sampson*, 65 Misc. 2d 658, 641 (Fam. Ct.), *aff'd*, 37 A.D. 2d 668, (1972); *In Re Carstairs*, 115 N.Y.S. 2d 314 (Dom. Rel. Ct. 1952).

[100] *See, e.g., A.L.* v. *G.R.H.*, 325 N.E.2d 501 (Ct. App. Ind. 1975); *In re M.K.R.*, 515 S.W.2d 467 (Mo. 1974); *Frasier* v. *Levi*, 440 S.W. 2d 393 (Civ. App. Tex. 1969).

where there was disagreement, it could be properly resolved through a hearing procedure. That is exactly the result sought by plaintiffs here, in the context of a proposed civil commitment.

Given the possibility for error and for basic conflicts of interests, this Court should not permit parental foreclosure of a child's right to be heard in connection with a decision as crucial to his life as commitment to a mental institution.

3. The Fiscal and Administrative Concerns of the State Do Not Outweigh the Child's Need for an Evidentiary Hearing.

There are over half a million admissions for inpatient treatment of psychiatric disorders made annually.[101] Evidentiary hearings are routinely accorded to adults who resist commitment and to children whose parents do not consent to commitment, and the states have not found the right to an evidentiary hearing a great fiscal or administrative burden. Extending that right to all children would result in little additional cost.

In Georgia, for example, only 154 children were confined in institutions pursuant to voluntary procedures on January 31, 1976. Nationally, only 9 percent of those receiving inpatient treatment are under 18 years of age.[102] One out of every three of these children is now committed on an involuntary basis pursu-

[101] National Institute of Mental Health, Statistical Note 90, Utilization of Psychiatric Facilities by Persons Under 18 Years of Age, U.S. 1971, Table 1 (1973).

[102] *Id.*

ant to an evidentiary hearing because his parents have objected to hospitalization.[103] Moreover, of the adults confined in state and county mental institutions, 52.9 percent have waived a hearing and committed themselves voluntarily [104] and, presumably, a substantial proportion of the children whose parents have consented would, after consultation with counsel, waive their hearings. Thus, the recognition of the hearing rights of children will result in only a minimal increase in the number of civil commitment hearings conducted. Moreover, as an erroneous commitment imposes a substantial unnecessary burden on the state in the form of costly inpatient care, an additional screening mechanism is likely to reduce overall costs to the state.

III. DUE PROCESS REQUIRES THAT CHILDREN SUBJECT TO INSTITUTIONALIZATION BE AFFORDED AN EVIDENTIARY HEARING.

The procedures required by the due process clause depend on "the need for and usefulness of the particular safeguard in the given circumstances. . . ." Friendly, *Some Kind of Hearing*, 123 U. Pa. L. Rev. 1267, 1278 (1975). As *amici* have demonstrated, the present "voluntary" commitment procedure fosters erroneous decisions to confine children to mental institutions which in turn result in serious harm to these children. An evidentiary hearing would substantially reduce the possibility of such erroneous decisions and consequent harm. *Cf. Mathews* v. *Eldridge*, 424 U.S. 319, 335

[103] This calculation is based on nationwide data on state and county mental hospitals reported in National Institute of Mental Health, Statistical Note 105, Legal Status of Inpatient Admissions to State and County Mental Health Hospitals, U.S. 1972, Table Ia (1972).

[104] *Id.*

(1976). While *amici* maintain that, in committing children to mental institutions, there is an indispensable need for an evidentiary hearing, we will not address here such issues as the forum for the hearing (*i.e.*, judicial or administrative), the applicability of formal rules of evidence and burden of proof required. The district court's judgment properly affords the Georgia legislature an opportunity to enact legislation addressing these issues. However, *amici* submit that any hearing procedure adopted must contain, at least, the minimum safeguards that have traditionally been required in cases involving the deprivation of liberty.[105] These include a hearing before an impartial officer with due notice,[106] counsel [107] and the opportunity to present and cross-examine witnesses.[108] These safeguards are

[105] *See, e.g., In re Gault*, 387 U.S. 1 (1967).

[106] Without adequate notice the right to a hearing is of little significance. *Mullane* v. *Central Hanover Trust Co.*, 339 U.S. 306, 314 (1950). Notice should include a statement of the factual and diagnostic bases for the proposed commitment, so that an adequate response can be prepared. *Cf. In re Gault*, 387 U.S. 1, 33 (1967).

[107] The value of counsel is demonstrated by a study by Wenger and Fletcher. They monitored nearly 100 commitment hearings in one court and found that in 91 percent of the cases in which only the psychiatrist, respondent and referee were present, the psychiatrist recommended commitment. But in only 26 percent of the cases in which counsel represented the respondent, was commitment recommended. Significantly, of respondents *without* counsel, 10 of 15 whom the authors judged not to be in need of commitment and all 25 who were thought to be borderline cases, were committed. Wenger and Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. of Health and Soc. Beh. 66, 68-71 (1969). *See also* Gupta, *New York Mental Health Information Service: An Experiment in Due Process*, 25 Rutgers L. Rev. 405, 437-38 (1974).

[108] In *Specht* v. *Patterson*, 386 U.S. 605, 610 (1967), the Court held that persons have the right to present evidence and confront

provided in most state statutes in connection with involuntary commitment proceedings,[109] and have been uniformly held to be constitutionally required by both state and federal courts.[110]

Of these minimum safeguards, the right to counsel is perhaps the most important. The presence of counsel will vastly improve the range and quality of the data that are brought to bear on the commitment decision. In addition to the likelihood that counsel will secure better information from the child, he will be in a position to obtain other relevant data that may not be volunteered by the parents, such as information relating to parental abuse of the child or attempts to commit other children of the family. In addition, counsel can secure and present the opinions of a psychiatrist not associated with the institution with regard to the need for confinement.

The presence of counsel would also facilitate an independent opportunity to consider alternative treat-

witnesses in commitment hearings held under the Colorado Sex Offenders Act. These rights are no less important here. While the right to appear personally is also essential if the juvenile is to have a fair opportunity to explain his behavior, there may be circumstances in which the absence of the child at the commitment proceedings may serve his best interest. Thus, we would suggest that the right to appear personally may be waived, either by the juvenile or by the child's counsel, and that such a waiver should be accepted by the hearing officer upon a finding that the child appears too ill to attend the proceedings.

[109] *See, e.g.*, 50 Pa. Stat. Ann. § 4406; D.C. Code § 21-541; Cal. Welf. and Inst'ns Code § 5300-05; Mo. Stat. Ann. § 202.807; Rev. Code Wash. Ann. § 71.05. 310.

[110] *See, e.g., Barry* v. *Hall*, 98 F.2d 222, 225-26 (D.C. Cir. 1938); *Suzuki* v. *Quisenberry*, 411 F. Supp. 1113, (D. Haw. 1976); *Doremus* v. *Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Kendall* v. *True*, 391 F. Supp. 413, 419 (W.D. Ky. 1975) (three-judge court); *Bell* v. *Wayne County General Hospital*, 384 F. Supp. 1085, 1091 (E.D. Mich. 1974) (three-judge court); *Lessard* v. *Schmidt*, 349 F. Supp. 1078, 1090 (E.D. Wis. 1972) (three-judge court), *remanded on other grounds*, 414 U.S. 473, *redecided*, 379 F. Supp. 1376 (1974) *remanded on other grounds*, 421 U.S. 957 (1975) *redecided*, 413 F. Supp. 1318 (1976); *Dixon* v. *Attorney General*, 325 F. Supp. 966, 974 (M.D. Pa. 1971) (three-judge court); *State ex rel. Fuller* v. *Mullinax*, 364 Mo. 858, (1954); *State ex rel. Hawks* v. *Lazaro*, 202 S.E.2d 109 (W. Va. 1974); *cf. Specht* v. *Patterson*, 386 U.S. 605, 608 (1967); *Minnesota ex rel. Pearson* v. *Probate Court*, 309 U.S. 270 (1940).

ment modes.[111] In this respect, social workers or other treatment professionals could be of assistance at the hearing.[112] In some cases, counsel may locate alternatives to institutionalization to which the parents may agree in advance of the hearing, thereby obviating the need for the commitment proceeding altogether.

Amici believe that an evidentiary hearing is not required when there is agreement among the parties regarding the appropriateness of institutionalization.

[111] "In New York City for example, where counsel-advocates work within the admitting hospitals, one of their principal functions has been to seek alternatives to hospitalization satisfactory to their clients (and to the hospital as well) so that long-term hospitalization together with the disabilities and dependencies it involves can be avoided." Andalman and Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic and A Proposal*, 45 Miss. L.J. 43, 47 (1974).

[112] *See, e.g.*, Ga. Code Ann. § 24A-601 to -02 which provides for a probation officer to assist juvenile courts in finding alternative placements for children under their jurisdiction, and Mich. Stat. Ann. § 14.800(469)(2), requiring reports to be filed with the court in the course of civil commitment hearings by agencies or individuals knowledgeable about alternative treatment programs in the person's home community.

However, the susceptibility of the child to professional or parental pressure to acquiesce to commitment suggests the importance of access to counsel before the child is permitted to waive his right to a hearing.[113] Without counsel such a waiver is likely to be the product of "fantasy, fright or despair," *In re Gault,* 387 U.S. 1, 55 (1967), rather than an "intentional relinquishment or abandonment" of a fully known right. *Johnson* v. *Zerbst,* 304 U.S. 458, 464 (1938).

In non-emergency cases evidentiary hearings should precede the commitment, just as they do in cases of adults. In these situations, no harm can result from the brief delay caused by a pre-commitment hearing. But children who are found at a hearing not to be in need of commitment will be spared the deprivation of liberty and the harm they would have suffered as a result of mistaken institutionalization pending a post-commitment hearing. A child's sense of time is such that even a few days in a mental institution can seem a lifetime.[114]

Indeed, if a child is permitted to remain at home pending the hearing, the crisis precipitating institutionalization may even diminish or disappear.[115]

Further, the literature suggests that pre-commitment hearings are preferable, in that post-commitment examinations and hearings increase the likelihood of decisions to commit.[116] This may be due to the impact on

[113] *Cf. Gallegos* v. *Colorado,* 370 U.S. 49, 54 (1962).

[114] A. 178.

[115] A. 179.

[116] *See* Babigian, Gardner, Miles and Romano, *Diagnostic Consistency and Change in a Follow-up Study of 1,215 Patients,* 121 Am. J. Psychiat. 395, 897 (1965).

the individual of confinement with persons who are seriously disturbed. *Cf. United States ex rel. Schuster* v. *Herold,* 410 F.2d 1071, 1078 (2nd Cir. 1969).

Amici respectfully submit that evidentiary hearings would be of great value to children subject to confinement in mental institutions. The evidentiary hearing can fulfill a therapeutic purpose for both parents and children by reviewing the reasons which allegedly justify hospitalization, whether the treatment the child needs can be provided outside of the institution,[117] what treatment the child will actually receive inside the institution,[118] how long he is expected to be institutionalized, whether and when his natural parents are willing and able to receive him back into their home, and what the child's desires are in the matter. All of these factors would be relevant in deciding whether the child is in fact mentally ill and "suitable for treatment," as the Georgia statute specifies.

With a hearing mechanism in place, the choice need not be between institutionalizing a child and returning him to a hostile and helpless family.[119] The decision-

[117] *See also,* A. Stone, Mental Health and Law: A System in Transition 12-14 (1975). Professor Stone argues that in our society institutionalization is generally overused because of the incorrect assumption (or perhaps hope) that "technical" assistance is available when often such expertise is lacking. As a result, we tend to seek scientific solutions where humane care and responsibility are what is needed. Thus, Stone urges a return to family responsibility, rather than the increased use of institutionalization.

[118] Thus, if the institution is substandard or not substantially in compliance with accreditation standards, or not equipped to administer the treatment or training the child needs, the child should not be institutionalized there.

[119] Experts agree that the majority of children presently institutionalized could be treated in the community if sufficient programs

maker in such a hearing can explore the family situation. He may arrange appropriate treatment for the child and/or the family. When only the child is institutionalized, the family's critical role in the treatment process is too often neglected.[120] A hearing officer can also order a thorough review of existing community alternatives. He can insist that the child be provided with the services by public agencies when the family has been frustrated by bureaucratic delays. Hearings can also satisfy a child's inherent sense of fairness and his need to be heard when he feels strongly that he is being dealt with unjustly.[121] Even in those cases where

existed. Joint Commission Report, *supra*, at 266-267. (1) Daytime and partial-hospitalization programs have proven successful for many mentally handicapped children as an alternative to institutionalization. *See, e.g.*, Fenichel, *A Day School for Schizophrenic Children*, 30 Am. J. Ortho. 130 (1960); R. Glasscote, Partial Hospitalization for the Mentally Ill (American Psychiatric Association and National Association for Mental Health Joint Information Service (1969). (2) Community services for the families of these children have also reduced the need for institutionalization. M. Gula, Child Caring Institutions: Their New Role in the Community Development of Services 19 (HEW 1958). (3) Specialized foster care programs for mentally handicapped children have been established in several states. Wolfensberger, *A New Approach to Decision-Making in Human Management Services*, in Changing Patterns in Residential Services for the Mentally Retarded, *supra*, at 379 (1969); Simmons, *et al.*, *Natural Parents as Partners in Child Care Placement*, 54 Social Casework 224-232 (1973). (4) Finally, group homes provide a substitute for mentally handicapped adolescents. M. Gula, Agency Operated Group Homes 1 (HEW 1964); Mosher, *et al.*, *Soteria: Evaluation of a Home-Based Treatment for Schizophrenia*, 45 Am. J. Ortho. 465 (1975).

[120] Joint Commission Report, *supra*, at 112-113, 263.

[121] *Cf. In re Gault*, 387 U.S. 1, 26 (1967).

> "[T]he appearance as well as the actuality of fairness, impartiality and orderliness—in short, the essentials of due process—may be a more impressive and more therapeutic attitude so far as the juvenile is concerned."

hospitalization is necessary, the hearing can relieve parents of the burden of unilateral action. And a hearing may improve the relationship between the child and the professional therapist. Once he has had a full hearing, the child may become more cooperative in the treatment plan. The therapist will perhaps no longer be perceived as a co-conspirator with the parents in committing the child.

Several studies suggest that an opportunity for juveniles to contest institutionalization at hearings will not interfere with therapy. Encouraging active participation of the patient in decision-making about his own future is a tenet of psychotherapy.[122] Adolescent as well as adult mental patients very often have a realistic notion of whether they need hospitalization.[123] And they have apparently exercised their existing limited rights to object to hospitalization in a way that has not

[122] *See, e.g.*, Tucker & Maximen, *The Practice of Hospital Psychiatry: A Formulation*, 130 Am. J. Psychiatry 889 (1973).

> "In the design of a hospital program it is . . . essential to create an atmosphere that encourages patients to take active responsibility for themselves and others. In other words, instead of being the passive recipients of the staff's therapeutic efforts, the patients should assume the role of change agents."

[123] In one study, patient and staff judgments agreed on the avoidability of hospitalization in two-thirds of the cases studied if alternative treatment were available in the community. This ratio was not significantly different for adolescent patients (over 14) than for adults. The study concluded:

> "Judgments made by patients, even though they are acutely more disturbed, are much more valid . . . than might have been expected. . . . The clinical significance of this is that the psychiatrist deciding upon admission versus alternative treatment can validly take into account the opinion of the patient."

Lipsius, *Judgments of Alternatives to Hospitalization*, 130 Am. J. Psychiatry 892, 895 (1973).

been unduly disruptive of hospital routine."[154]

In sum, providing an evidentiary hearing to children subject to confinement in mental institutions can help to decrease unnecessary and damaging institutionalization [155] and to bring to bear on the unfortunate situation of emotionally disturbed children the attention and community resources they require.[156]

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[154] Meisel, *Due Process in the Civil Commitment of Children*, 10 Psychiatric Spectator 5-6 (1975).

[155] The Department of Health, Education and Welfare cites studies showing only one-third of the children in St. Elizabeths Hospital and 20 Texas mental hospitals need hospitalization. National Institute of Mental Health, Statistical Note 115, Children in State Mental Hospitals, 4 (1973).

[156] *Amici* have documented the serious harms attendant upon institutionalization of children and the unreliability of parental and psychiatric decisions concerning its necessity. For these reasons, children must be accorded an evidentiary hearing to determine the need for institutional commitment. The harm is such that children must be protected even for confinements of short duration. At the same time, however, *amici* recognize the legitimate interests of conscientious parents and their professional consultants in meeting the need for short-term psychiatric observation and diagnosis of emotionally disturbed children.

In *amici*'s view, the proper balance of the child's and parents' interests would allow parents of younger children to place them in mental institutions for observation and diagnosis for a brief period, *e.g.*, one week, when it is not possible to conduct an evaluation on an outpatient basis. Even under such circumstances, however, it is imperative that safeguards exist to reduce the potential harm to the growing child which stems from even short-term institutionalization. *Amici* therefore suggest the following:

(1) That children placed for evaluation be housed in residential settings segregated from the general institutional population and in facilities used exclusively for children; *Cf., United States ex rel. Schuster* v. *Herold*, 410 F.2d 1071 (2nd Cir. 1969); *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973);

(2) That during the period of the evaluation, children should not be subjected to intrusive therapy modalities, *i.e.*, psychotropic drugs, electroconvulsive therapy, psychosurgery;

CONCLUSION

For the reasons set forth above, *amici* urge this Court to affirm the judgment of the court below.

Respectfully submitted,

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(3) That following the evaluation period children should be released from the mental institution to the custody of their parent or guardian. Any subsequent decision to seek commitment of the child must be preceded by the evidentiary hearing contemplated for commitment proceedings of all children.

Amici urge that older children, *e.g.*, 14 and over, should be provided with an evidentiary hearing to determine the appropriateness of a placement for observation and diagnosis, if they do not consent to it. Research into the cognitive and moral development of children gives credence to the legal claims of adolescents to participate in important decisions which affect their future. According to Jean Piaget, children from about the age of 12 possess the ability to conceptualize and engage in abstract reasoning and can apply such reasoning to situations in which they are personally involved. And while parents obviously continue to maintain a strong interest in the upbringing of their adolescent children, they must necessarily cede an increasing measure of control over their destinies to the children themselves. *See*, J. Piaget, The Moral Judgment of the Child (1965); J. Piaget, The Origins of Intelligence in Children (1952); Piaget, *Intellectual Evolution from Adolescence to Adulthood*, 15 Human Devel. 1-12 (1972).

* Counsel for *amici* wish to express their appreciation to law students Kay Rigling and Teri Sklar for their assistance in the preparation of this brief.

Dated: September 21, 1977